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Community Based and Public Health Nursing

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Introduction

The distinction between community based and public health nursing is critical to a quality, coordinated health delivery system. Public Health Nursing is population-focused and community oriented, whereas community based care focuses on individuals and families in their natural settings within communities.

In today's environment of health care reform, federal, state and private market forces are calling for the development of community based, competent comprehensive, convenient and accessible health care delivery systems. A community-based, population-focused approach to planning, delivering and evaluating nursing care has never been more important, thus professional nursing needs to realign its allegiance and accountability by shifting from the historical emphasis of the profession to respond to these trends. Community based nursing is changing dramatically in response to new federal reimbursement methodology. Prospective Payment Rules are just being drafted for the new systems which are expected to curtail services or even jeopardize survivability.

All sectors of the health care delivery system will continue to shift, necessitating shifts in nursing practice to accommodate new practice settings, policies, reimbursement policies and expanding roles. The nursing profession has changed its definition and priorities for public health nursing practice significantly since 1996. Four major developments have shaped this landmark change: a) publication of the scope and standards of public health nursing practice (ANA with input from ACHN, APHA), b) efforts to encourage baccalaureate nursing education programs to better prepare nurses for population-focused nursing practice, c) programs to educate public health nurses in core public health functions and population- focused nursing practice and d) development of a public health intervention model and evidence-based practice guidelines for public health nursing.

The skills associated with community based care need to be identified and incorporated into professional nursing practice. To define the future role of nursing in delivering health care in the community, differentiation between community based nursing (CBN)/home health nursing and public health nursing (PHN) must be articulated. This paper will address the definition for community based nursing and public health nursing, the history of nursing in the community, the

current reality in the state of South Dakota, implications for nursing education, nursing practice and nursing regulations and recommendations for further study.

Definitions

Community-based and Home Care

Community based nursing/home health is defined as a philosophy of nursing that guides nursing care provided for individuals and families wherever they are, including where they live, work, play or go to school. The practice is characterized by an individual and family-centered orientation, the development of partnerships with clients and an appreciation of the values of the community. CBN/home health nursing is applied to all nurses who practice in the community whether or not they have had preparation in public health nursing. Major role activities include case management, patient education, individual and family advocacy and an interdisciplinary approach. (Zotti, Brown, Stotts, 1996)

Public Health Nursing

Because of changes in the health care delivery system and the need for population-focused nursing practice, differing definitions of community health nursing (ANA, 1985) and public health nursing (APHA, 1996) were recently synthesized. Through an unprecedented collaborative effort between ANA, APHA Public Health Nursing Section, Association of State and Territorial Directors of Nursing and the Association for Community Health Nursing Educators, there is now one document called the Scope and Standards of Public Health Nursing Practice (ANA, 1999).

Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences (ANA, 1999). Public health nursing is a population-focused, community-oriented approach aimed at health promotion of an entire population and prevention of disease, disability and untimely death in a population. Future public health services will be driven by local community needs, resources and preferences of the people. Therefore, all public health nurses must have a broad range of population-focused and community-oriented skills to be strong public health team partners.

Currently the DHHS Division of Nursing is funding initiatives to educate baccalaureate nursing students in the core public health functions and complex interdisciplinary practice. The impetus for these changes is the demand for nurses who can assess the health needs of populations, identify high risk target groups for intervention and implement public health interventions that achieve desirable population-based health outcomes. The American Association of Colleges of Nursing (AACN) emphasizes as essential the following PHN functions: population based needs assessment, work with diverse populations and interventions tailored to achieve desirable population based health outcomes. (AACN, 1998) The Division of Nursing is also funding innovative projects that provide continuing education for nurses in medically underserved areas. Some of these projects have created innovative continuing education programs which target PHNs practicing in rural and underserved areas. The Minnesota Department of Public Health Nursing is conducting such a project in five states including South Dakota. The project provides a year of training for PHNs, which culminates in national satellite training for PHNs.

The project provides a population-based focus, offers tools for future practice and expedites access through distance learning technologies. Eight nurses working for the SD Department of Health attend this program. SD PHN faculty are involved as expert panelists and preceptors. (MN Department of Health)

Eight tenets of public health nursing have been developed to guide the practice:

1. Population-focused assessment, policy development, and assurance processes are systematic and comprehensive.
2. All processes must include partnering with representatives of the people.
3. Primary prevention is given priority.
4. Intervention strategies are selected to create healthy environmental, social and economic conditions in which people can thrive.
5. Public health nursing practice includes an obligation to actively reach out to all who might benefit from an intervention or service.
6. The dominant concern and obligation is for the greater good of all of the people or the population as a whole.
7. Stewardship in allocation of available resources supports the maximum population health benefit gain.
8. The health of the people is most effectively promoted and protected through collaboration with members of other professions and organizations.

A public health nurse is a person who has received specific educational preparation at the baccalaureate degree level and supervised clinical practice in public health nursing. The public health nurse places priority on community-oriented prevention, protection and health promotion. Major role activities include case finding, patient education, program planning, implementation, evaluation and community development. Public health nurses can deliver care to individuals and groups, but they are primarily responsible for the health of the population as a whole, with special emphasis on identification of high-risk aggregates and appropriate interventions.

The public health intervention model developed by the Minnesota Project describes the work of public health nurses in a rapidly changing health care delivery system. The PHI model was developed by PHNs through a collaborative process. The model represents 17 population-based interventions performed by PHNs at the level of individual, family, community and systems. (Olson Keller, Strochein, Lia-Hoagberg & Schaffer, 1998) Appendix E

1. Advocacy
2. Case management
3. Coalition building
4. Collaboration
5. Community organizing
6. Consultation
7. Counseling
8. Delegated medical treatment and observations
9. Disease investigation
10. Health teaching

11. Outreach/case findings
12. Policy development
13. Provider education
14. Referral and Follow-up
15. Screening
16. Social marketing
17. Surveillance

Public health nursing interventions have been traditionally recognized by the site of service delivery (school health, immunization clinics, home visits). The PHI model transcends this service-site orientation by describing the direct and indirect service interventions that improve population health. For PHNs, the PHI model helps to document and justify their interventions as cost-effective and outcome-oriented rather than service-oriented. The PHI model assists with educating PHN students by clearly defining public health nursing practice as population based. The model also provides a means of describing the work of PHNs directed toward the community or system as client. Finally, the PHI model helps nursing students to develop population-focused, community-oriented nursing skills. (Fahrenwald, Fischer, Boysen & Maurer, 1999)

While the Agency for Health Care Research and Quality has developed some guidelines for evidence-based nursing practice, there are no such guidelines for public health nursing interventions. Evidence-based clinical practice guidelines for PHN practice are being developed for the 17 public health interventions. (Strochein, Schaffer & Lia-Hoagberg, 1999)

Public health nurses practice within the functions of public health as defined by the Institute of Medicine (1990). The three core public health functions (assessment, policy development and assurance) overlay all public health interventions. Each intervention has an assessment, assurance, and policy development component, although in varying degrees.

- **Assessment** is the regular collection, analysis and sharing of information about health conditions, risks, and resources in the community.
- **Policy Development** uses the information gathered during assessment in the development of local and state health policies.
- **Assurance** focuses on the availability of necessary health services throughout the community. It includes maintaining the ability of both public health agencies and private providers to manage day-to-day operations as well as the capacity to respond to critical situations and emergencies.

All three of the core functions are achieved through both direct and indirect service to the client.

The Table in Appendix A adapted from Zotti, Brown and Stotts (1996) and Williams (1996) further assists in differentiating community based nursing/home health and public health nursing.

Trends in Health Care Delivery: The Move Toward Community

The number of hospital admissions in South Dakota has declined from 123,014 annually in 1980 to 88,187 annually in 1995. During that same period of time, the average length of stay dropped from 6.1 to 4.9 days. Declining admissions rates and length of stays combined to sharply reduce the total number of hospital inpatient days from 750,384 in 1980 to 431,419 in 1993. Hospital occupancy dropped from 65% in 1980 to 37% in 1995. (SDAHO, 1995) This was largely due to changes in Medicare reimbursement (DRGs). This is comparable to national trends.

Trends in home health care delivery have been dramatic nationally and in South Dakota largely due to changes in Medicare since the 1960s. In 1966, Brown County Health Department conducted a pilot project demonstrating the effectiveness of home health care. In 1968, SSDCL Chapter 24-3A was passed in South Dakota to allow counties to establish home health agencies. By 1972, 22 counties in the state ran Medicare-certified home health agencies and employed both nurses and aides. In 1979, to ensure the services were available to residents of all counties, the legislature authorized the Department of Health (DOH) and the Department of Social Services (DSS) to collaborate and develop a statewide home health agency. This legislation also authorized the DOH to hire all the county Medicare nurses and the DSS to hire all the county aides.

In 1983, the implementation of diagnosis related groups (DRGs) under Medicare and its effect on reimbursement caused many small to mid-sized hospitals to develop or consider developing their own home health agencies. Between 1984 and 1985, the number of Medicare-certified home health agencies more than doubled from 9 to 19. As a result, the DOH saw a downward trend in its home health visits and reduced staff accordingly. The factor directing this decision was the decrease in revenue as the fee-for-service clients were seen by private agencies at an increasing rate, leaving the non-pay clients for the DOH to absorb in many cases.

In the last few years, the trends toward integration of health care services and declining inpatients combined to make operating a home health agency an option to hospitals. Many canceled their contracts with the DOH and developed their own agencies. Federal reimbursement for hospital-based home health services has dipped, making this service less attractive for hospital revenue streams.

In 1993, there were 26 Medicare-certified home health agencies in the state; by 1995 there were 64 certified agencies. At the same time, the number of skilled home health visits made by DOH nurses declined 74% between fiscal year 1993 and fiscal year 1996.

As a state agency, the Department of Health discontinued home health care statewide in December 1995. There were 50 private Medicare-certified home health agencies, and at that time more anticipated, in a state of 700,000 people. The department felt confident the private sector could meet the home health needs of South Dakota residents. DOH felt it could make the most effective use of its limited resources by not duplicating services readily available in the private sector.

Beginning in November 1995, DOH transferred 700 home health patients to the private sector. As of January 1, 1996, DOH no longer accepted any home health referrals. Home health care in South Dakota is privatized and the agency's only role is the Medicare survey process conducted by the Licensure and Certification Program.

In 1989, the Department of Health initiated a special project called "Health 2000" aimed to prevent health problems in dozens of areas from breast cancer to measles. "Health 2000" mirrors the national "Healthy People 2000" initiative in its emphasis on preventing health problems and helping people take personal responsibility for their own health. The current plan is entitled Health 2010 based on the National Healthy People 2010 project. See Appendix B for a chronology of Selected Historical Events.

Current Reality of Nursing in the Community

Community-based nursing and public health nursing will be further differentiated by a grouping of current services provided in the state by community-based nursing and public health nursing.

Community Based Nursing Service/Home Health

The community based nursing services are provided primarily through home health agencies. With the advent of Medicare and Medicaid in 1965, home health care became a growing industry. South Dakota has 64 home health agencies which are either based within government, private corporations, or hospitals and/or nursing homes. A home health agency is either located in each county in South Dakota or the county has either direct access to a home health agency within the county's border or indirect access for the county from an agency located in another county.

Individuals and families experiencing acute and chronic health problems are the clients of home health nursing. The goal of home health nursing is individual and family self-care. This cost-effective, illness-oriented, direct-care service is now considered commonplace in the USA, where government cutbacks on reimbursement and sky-rocketing health care costs have meant shorter stays in acute-care facilities.

The majority of care provided is to elderly and disabled individuals. Medicare cutbacks have reduced the percent of home visits reimbursement by this source. Qualified Medicare payment secures services for individuals who are: homebound, under a physician's plan of treatment, and have an unstable medical condition that requires one or more of the primary services of skilled nursing, physical therapy, occupational therapy, or speech therapy. Care is provided through a multidisciplinary approach with nurses providing the overall case management.

Home health agencies also provide care to clients whose private insurance includes home health benefits or clients who choose to private pay. Commercial insurance companies are increasingly offering case management programs that include home health services as an alternative to more expensive institutional care. Private pay is the least frequent payment source for home health care. A specific breakdown of the percentage of payors in each category is presently unavailable.

Home health agencies may also contract with the Department of Social Services for a number of programs to provide patient care. Nurses and assistive personnel provide the majority of care. Eligibility and level of care for these programs is determined by an assessment by a social worker. The first level of care provided is the Homemaking Service that provides homemaker services with assistive personnel providing the care. The second level is personal care which provides the patient a high level of personal care with nursing visits approximately once per month to supervise the care provided. The third level is the Long Term Care Alternative Program (LTCAP) in which the patient receives homemaking, personal care and skilled nursing care. The fourth level is the Title 19 Waiver Program in which the highest level of nursing care is provided. These patients must qualify for Medicaid. The majority of care provided in home health is through the homemaker service and the LTCAP Program.

Public Health Nursing

South Dakota Department of Health

The South Dakota Department of Health's role in health care has been to prevent disease and promote health to ensure access to needed, high-quality health care and to efficiently manage public health resources. The organizational structure of the Department of Health consists of three primary divisions (see Appendix C). These are the Division of Administrative Services, the Division of Health Systems, Development and Regulation and the Division of Health and Medical Services. The Health and Medical Services Division emphasizes direct health services to families, adolescents, mothers and children. Nursing plays a major role in this division through the services of community health nursing, maternal and child health program, nutrition programs, children's health services, communicable disease control and disease prevention activities.

Division of Health and Medical Services

Within the Division of Health and Medical Services, there are four offices which employ nurses. These four central offices employ a total of eight nurses, one MS prepared and seven bachelor's prepared who provide a variety of services for the Division. They may include assessment which involves the collection, analysis and interpretation of health data through program planning and evaluation; leadership and policy development to assure that effective policies are implemented through policy development and community mobilization; assurance which assures there is an entity to provide essential public health services; administration, acquiring and targeting resources to ensure services can be provided through grant management activities; and access and coordination designed to strengthen access to or directly provide essential health services through population-based public health planning.

Community Health Services/Family Health/Disease Prevention and Health Promotion

The nursing care delivered to the community is delivered through the Community Health Services. Thirty-seven of South Dakota's 66 counties have a contractual agreement with the South Dakota Department of Health/Community Health Services to provide all community health services programs. Sixteen counties have only contracted with the state for WIC Program services.

Services are determined primarily by funding sources. Currently, the Department of Health has the following grants or contracts to deliver services: WIC, MCH block grant, Family Planning, Health Service Fees, Breast and Cervical Cancer Screening, HIV prevention and surveillance, Immunization and TB. Very limited general funds are used to support PHN services.

The types of services provided through Community Health and the nurses' role are briefly described below:

- School Health Services are provided in the school where there is a contractual agreement between the South Dakota Department of Health and the local school district. Nurses provide health screening, individual or group education, referral and follow-up to both students and faculty.
- WIC Program services is a nutrition education and food supplement program for infants, children to age five, pregnant, breastfeeding and postpartum (6 weeks) women. Program eligibility is based on income, nutrition and medical risk factors. Nurses complete a nursing assessment which involves anthropometric and biochemical data, health history, and nutrition assessment and then provides appropriate education based on identified needs.
- Immunization services are provided for vaccine preventable diseases, influenza, and tuberculosis screening/referral/follow-up to all age groups. The nurse provides immunizations according to the Advisory Committee on Immunization Practice for preventable diseases, markets and assists in elimination of barriers to assure age appropriate immunizations. The nurse conducts tuberculosis screenings per guidelines for individuals or groups with referral and follow-up of abnormal findings.
- Family Planning services are provided to individuals. Nurses counsel, educate, and provide provisions for contraception to those individuals seeking family planning services. Nurses complete on-site physical examinations under contractual agreements with physicians or mid-level practitioners tat the Community Health Services offices in Rapid City, Aberdeen, Pierre, and Brookings. Other nursing offices refer to local providers for the physical examination.
- Prenatal Risk assessment, prenatal education, and case management are provided. Nurses complete a standard risk assessment on all pregnant women and provide on-going education, counseling, and assessment of the women during pregnancy. Referrals to other health and medical resources are done as needed.
- Postpartum visits, counseling and education are provided. Nurses conduct postpartum home visits, assess mother and newborn, provide appropriate education and counseling, and make referrals to other appropriate services.
- Developmental screening for infants and children are conducted. Nurses conduct developmental screenings using Revised Parental Development Questionnaire and Denver II, well-child assessments and provide anticipatory guidance education and counseling.

- Health screening, counseling, and education services to individuals or groups in all age categories on public health disease prevention and health promotion topics are delivered. Nurses complete health screenings and education for blood pressure, glucose, hemoglobin, vision, hearing, scoliosis and urine screenings and make referrals. Nurses educate individuals or groups on a broad range of public health prevention topics or health promotional topics.
- Community Health assists with client-need coordination and community networking. Nurses serve as a local resource for individuals, families or communities and assist them in finding appropriate resources to address needs or public health issues.
- Maternal Child Health home visits for anticipatory guidance, counseling, screening, and education are provided. Nurses assess, educate, and provide guidance to parents and children who have high risk factors of the home, parent or child.
- They provide assistance with other communicable disease activities such as lice screening, disease outbreak, etc. Nurses work closely with Department Disease Intervention staff in identified communicable disease issues or in the area of prevention of communicable disease.
- Assessment and treatment of individuals in local offices as ordered by a licensed physician are provided. The services may include education of a new diabetic client, assistance with medication management, venipuncture, suture removal, education and counseling, maintenance injections of B-12 or psychotropic medications. This is more common in communities where there is not easy access to a private provider.

In addition to the 8 nurses employed in the central office, the Community Health Service employs 68 Registered Nurses. As of July 2000, 26 are Baccalaureate prepared, 18 are Diploma prepared and 27 are Associate Degree prepared. There are three Licensed Practical Nurses and no Master's prepared nurses. Salaries are not competitive with the private sector, so recruitment and retention of qualified public health nurses is becoming increasingly difficult. One PHN vacancy took six months to fill.

Alternative Public Health Delivery System: Public Health Alliance

In April 1996, the first Alternative Public Health Delivery System (APHDS) began delivering services. The goal of the Public Health Alliance program is to support local health care systems while making the most efficient use of the Department of Health resources. Presently, community health services are delivered in 13 sites of 12 counties through unique partnerships involving local county governments, local health care providers and the department of health. Where the department once delivered community health services, it now contracts with private health care providers to deliver them under the Public Health Alliance. (Appendix D)

The counties of Brule, Deuel, Douglas, Edmunds, Faulk, Hand, Hutchinson, McPherson, Moody, Tripp, Turner and Walworth are currently providing public health services through this arrangement. This project employs 20 Registered Nurses of various educational levels as well as Licensed Practical Nurses. The nurses are employed by the local hospital. The nurses' roles in these counties may be expanded to meet the needs of the local hospital or home health agency. A Community Health Council advises on community health service. These members help to monitor

and ensure accessibility and quality health care, implement initiatives to improve health status in the community and conduct community assessments. (www.state.sd.us/doh/address/comm.htm.)

Indian Health Service (IHS) Public Health Nursing

Within South Dakota, there are 10 public health nursing agencies offered through Indian Health Services or a tribal public health nursing agency. Nine of these agencies are reservation-based and provide public health nursing (PHN) services to tribal nations in South Dakota through an IHS or tribal PHN program. The Sioux Nations include Cheyenne River, Crow Creek, Flandreau, Lower Brule, Oglala, Rosebud, Sisseton-Wahpeton, Standing Rock and Yankton. The one urban agency serves the Native American people in Rapid City and the immediate surrounding area.

Services are provided to individuals and groups of all ages in a variety of settings: home, clinic, community and school. The primary focus for the 10 PHN programs is on the prevention of illness and injury and the promotion and maintenance of health. Services include activities such as home visits to individuals and families for teaching and counseling, immunization and well-child clinics, prenatal and diabetes classes, screening and outreach services, follow-up of communicable diseases, case management for the sick and elderly in the home, school nursing services and others. Services will vary with each program and are tailored to the specific needs of the communities and population served by the program. For IHS programs, home health care services are provided through referral to certified home health agencies or integrated within the generalized public health nursing service to the extent resources are available. Generally, tribal programs have included homecare within the scope of services.

Thirty-eight nurses are employed by 8 IHS and 2 tribal PHN agencies. Ninety-two (92%) percent of these 38 nurses have a bachelors degree in nursing. Using the Indian Health Service Resource Requirement Methodology (RRM) for determining staff levels, the current staff represents less than half of the professionals required for the service population.

School Nursing

In South Dakota, school nurses and public health nurses provide nursing services to children, pre-school through 12th grade. According to the State of South Dakota Department of Health Office of Coordinated School Health, information on the number of schools that employ a school nurse is available through the Department of Education and Cultural Affairs. Nursing services are provided in selected schools to the regular student population and to students with disabilities. Services vary with each district and depend upon the needs of the school, population served and funding. The following is a list of some of the services available:

preschool screenings	health assessments	audio screenings
child abuse reports	visual screenings	home visits
height/weight	accident reports	head lice checks
blood pressures	dental checks	scoliosis checks
catherizations	tube feedings	blood sugars
first aid	individual health care plans	growth & development
acute illness surveillance	tobacco prevention	hygiene education
medication administration	nutrition	AIDS, CPR, safety classes

Implications for Nursing Practice, Education and Regulation

As nurses shift from providing care from the institutional setting to the home and community, the specific educational preparation and skill sets must be identified for community-based and public health nursing. Incorporating the concepts of primary care practices versus an illness-oriented medical practice will need to occur. Nurses will need to have skills in assessment, critical thinking, teaching, negotiation, collaboration, delegation and leadership. They will also need to shift this focus from individuals to communities and populations. Advanced practice nurses will need additional skills of policy formation, research, consultation, collaboration with managed care groups and case management. The number of advanced practice nurses will need to be increased as health care continues to be more complex. A variety of clinical experiences in community settings will need to be available for students to practice the above identified skills. Nurses will function in roles of case management, education, researcher, collaborator and advocate.

The roles of assistive personnel, licensed practical nurses, associate degree nurses, baccalaureate nurses and advanced practice nurses will need to be clearly delineated. Clear articulation of roles will be essential for the provision of nursing care for community-based nursing and population-focused nursing. Core content for each nursing program needs to be outlined.

Nursing practice settings will be challenged by the need to care for individuals, families, groups and communities across the health-care continuum. Case management for patients with complex needs will need to be provided as patients continue to be discharged sicker and quality, cost-effective care is essential. Practice settings will need continued collaboration with the educational system to provide nurses skilled in providing care in an acute setting with the skill set needed to move to the community setting. Many diverse skills are required for PHNs to function effectively given all these complexities.

Regulation will need to address the revisions needed in the Nurse Practice Act as nurses move to the community. Revisions in the educational standards regarding supervision of students in community settings will need to be evaluated.

Recommendations for Further Study

This paper was written with input from a number of nurses and non-nurses employed in the services described. After the paper was reviewed by the study group, many questions were raised that this paper was unable to address. Based on the input received, the following are recommended for further study:

Conduct a comprehensive study of all public health and community-based nursing agencies to assess if the needs of South Dakota citizens are being met and make recommendations. Questions to be addressed in the study include:

1. Who will be the voice for the underserved in South Dakota? With the changes in medical reimbursement, the increase in the number of uninsured and the growing percentage of the state below poverty level, these items need to be addressed.

2. Are the philosophies of the profit agencies and public health different? If so, will this be a problem in meeting the needs?
3. What public health services are private enterprise providing and are they meeting the needs?
4. With the large variety of services being offered, are we evaluating whether the needs are being met?
5. What comprehensive strategic planning can be done to address shifting Federal reimbursement policies?
6. Are there opportunities to impact the health of South Dakota by allocating more resources to the children in the state through school health nursing?
7. How will the changing demographics of urban, rural and frontier affect the services that are provided?
8. What are the implications of cutting community health nursing home visits in South Dakota?
9. Is the educational preparation of nurses providing community based nursing and population-focused nursing adequate? What level of preparation is needed for each? What can be done to address educational needs of currently practicing community based and public health nurses?
10. Should the state of South Dakota certify that a nurse seeking employment in the public health system has included preparation in public health nursing?
11. What can be done about non-competitive salaries for public health nurses?

Appendix A

Practice Models of Community Based Nursing and Public Health Nursing

Model Component	CBN	PHN
Goals	Manage acute or chronic conditions Promote self-care Clinical nursing care delivered in the community	Preserve/protect health Promote self-care Population focused practice
Client	Individual and family	Community and Population at risk
Underlying philosophy	Human ecological model nurse provided care wherever the client lives	PH intervention model: Include health promotional activities, education and services to individuals, families & systems
Autonomy	Individual and family autonomy	Community autonomy Individual rights may be sacrificed for good of community; social justice is underlying principle
Client character	Across the lifespan	Across the lifespan with emphasis on high risk aggregates
Cultural diversity	Culturally appropriate care of individual and families	Collaboration, coalition building and mobilization of diverse populations
Type of service	Direct	Direct and Indirect
Home visiting	Home visitor	Case finding & management of high risk
Service Focus	Local community	Local, state, federal, and international

Olson-Keller, Strochein, Lia-Hugberg, B. & Schaffer, M. (1998) Population based public health nursing intervention: a model for practice. Public Health Nursing. 14, 207-215.

Zotti, M., Brown, P., and Stotts, R. (1996). Community-based Nursing Versus Community Health Nursing: What Does It All Mean? Nursing Outlook, 44, 211-217.

Community-Based Population-Focused Practice: The Foundation of Specialization in Public Health Nursing. Perspectives in Health Care Delivery and Community Health Nursing.

Appendix B

Chronological History of Nursing in the Community

A chronology of selected historical events for community-based and public health nursing are portrayed from a national perspective as well as for South Dakota.

1879 An act was passed to enable the National Board of Health to cooperate over a 4-year period with states on the matter of public health.

1891 South Dakota Board of Health is formed with headquarters in Waubay.

1917 The South Dakota Legislature passes legislation providing for a county public health nurse program.

1922 The Division of Public Health Nursing was formed.

1927 The South Dakota Legislature makes severe funding cuts for Board of Health programs and the Public Health Nursing is one division eliminated as a result.

1947 The State Board of Health becomes the South Dakota Department of Health. The Division of Public Health Nursing is re-established.

1965 The Social Security Amendment of 1965 established Medicare and Medicaid. This changed home health care from a nursing focus to a medical focus.

1966 Medicare and Home Health Care began in Brown County as a pilot project.

1979 After much study and discussion with the county commissioners, the existing county certified home care programs become a part of the state Community Health Nursing Program in South Dakota and the Medicare nurses become state employees (rather than county employees).

1982 The first annual meeting of the National Association of Home Care was held with the goal to unite the rapidly growing ranks of home care providers in a single national organization.

1983 President Reagan signed Public Law 98-28 which changed payment for Medicare hospital stays. Patients were now discharged “quicker and sicker” from hospitals.

1986-88 In South Dakota, Governor Janklow appointed a Task Force on Elderly Care. Led to nursing home bed moratorium which led to the Long Term Care Alternatives Program designed to keep patients out of nursing homes.

1988 In cooperation with the Department of Social Services, Community Health Nursing in South Dakota implements a preadmission assessment program for all individuals seeking admission to a nursing home. The mandatory assessment was part of Governor George Mickelson's elderly initiative.

Community Health Nursing begins providing case management services to those pregnant women covered by Medicaid who are at high risk for complications.

1989 Promoting health/preventing disease: Year 2000 Objectives for the Nation was adopted.

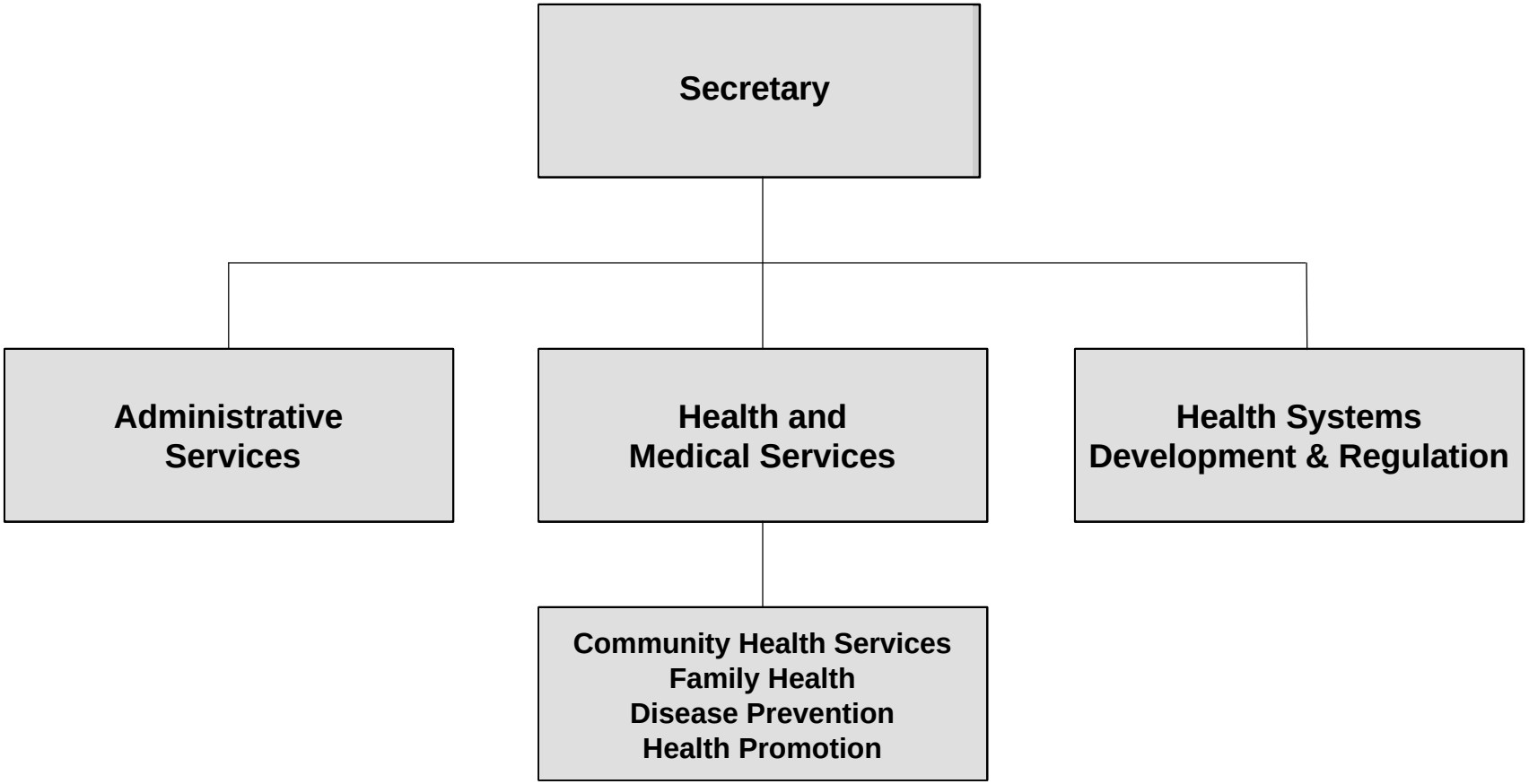
1995 South Dakota Department of Health no longer provided Home Health Services.

1996 South Dakota Department of Health published the South Dakota Health Check-up which contains demographic and health data at the county, state and national level. South Dakota Department of Social Services began contracting with private agencies for care. Appendix C

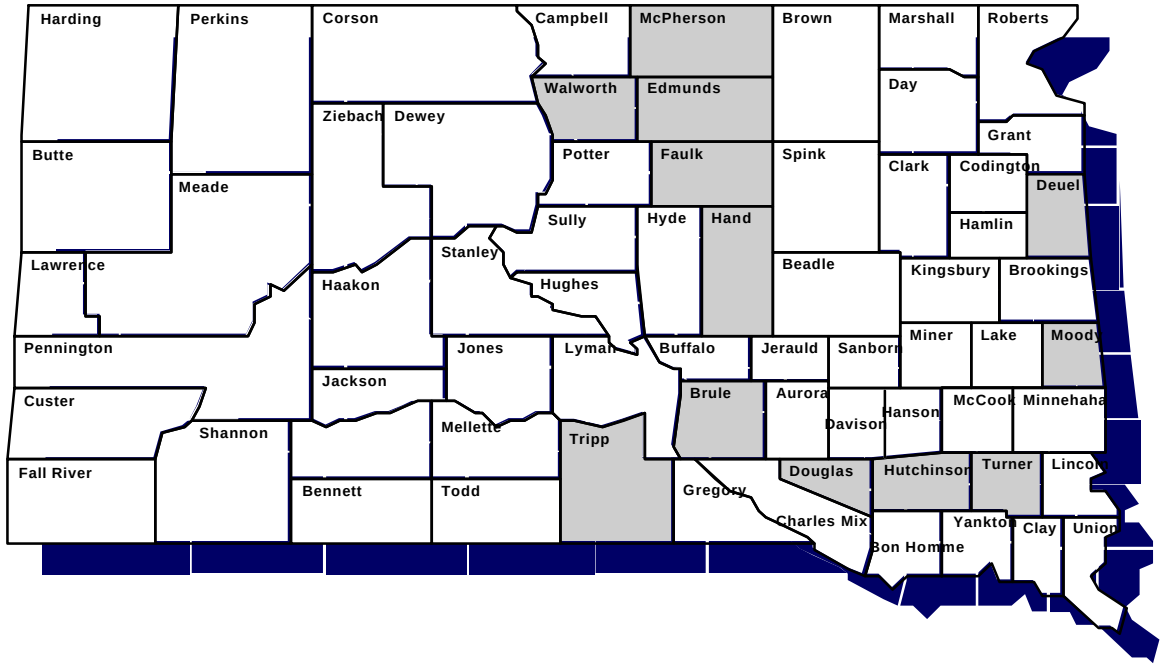
1996 The South Dakota Alternative Public Health Delivery System was formed. Through unique partnerships involving local county governments, local health care providers and the Department of Health, community health services are delivered to selected sites in South Dakota.

1999 South Dakota nursing faculty provide expertise as panelists and preceptors for Minnesota Division of Nursing project to educate public health nurses in core functions and the public health interventions. Eight SD PHNs participate in the project.

South Dakota Department of Health



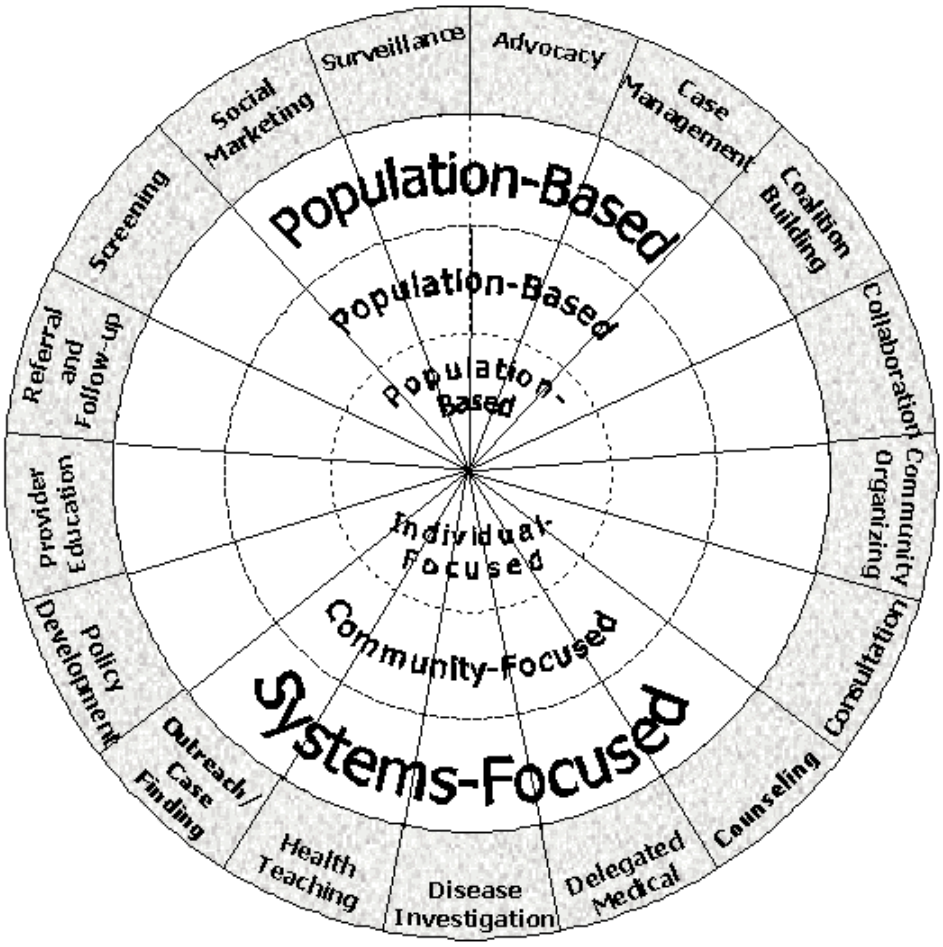
Public Health Alliance Sites



www.state.sd.us/doh/address/comm.htm, September 2000

Appendix E

Public Health Interventions Model



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